



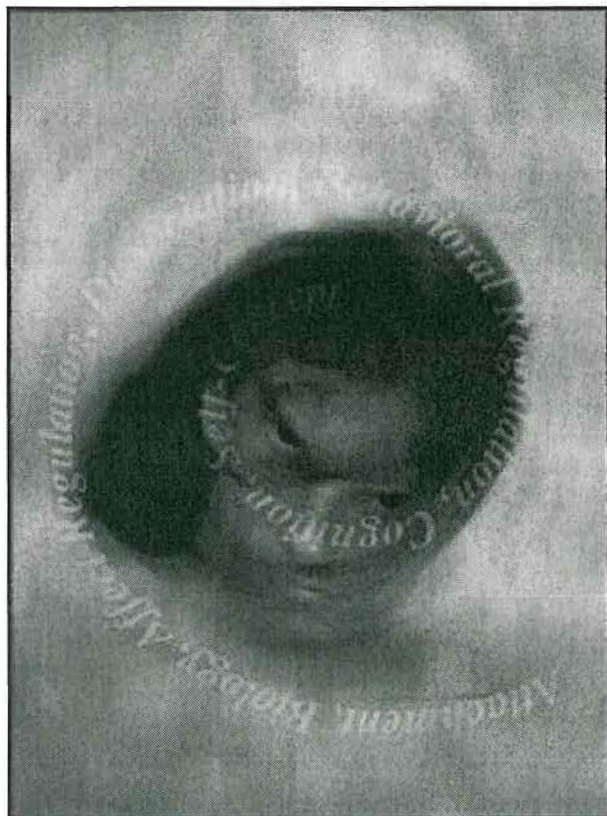
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Complex Trauma in Children and Adolescents

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Full Text (4934 words)

capacities tend to disintegrate, leaving them disorganized cognitively, emotionally, and behaviorally and prone to react with extreme helplessness, confusion, withdrawal, or rage.⁷



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In middle childhood and adolescence, the most rapidly developing brain areas are those responsible for three core features of "executive functioning" necessary for autonomous functioning and engagement in relationships. These features, involving primarily the prefrontal cortex, are conscious self-awareness and genuine involvement with other people, ability to assess the valence and meaning of complex emotional experiences, and ability to determine a course of action based on learning from past experiences and an inner frame of reference informed by understanding others' perspectives. Traumatic stressors or prior deficits in self-regulatory abilities that manifest during adolescence, in the absence of sustaining relationships, may lead to disruptions in regulation of affect, behavior, consciousness, cognition, and self-concept integration.

It is important to note that stressors early or later in life that are predictable, escapable, or controllable, or in which responsive caregiver contact is available and safe opportunities for exploration are reinstated, tend to enhance biological integrity.

Affect Regulation

Posttraumatic impairment of attachment and neurobiological integrity can lead to severe problems with affect regulation. Affect regulation begins with the accurate identification of internal emotional experiences, which requires the ability to differentiate among states of arousal, interpret these states, and apply appropriate labels (eg, "happy," "frightened"). Deficits in the ability of maltreated children to discriminate among and label affective states in both self and others have been demonstrated as early as age 30 months.⁸

Following the identification of an emotional state, a child must be able to express emotions safely and to modulate or regulate internal experience. Complexly traumatized children show impairment in both of these skills. Children with complex trauma histories evidence both behavioral and emotional expressions of pathology due to impaired capacity to self-regulate and self-soothe. These expressions may include dissociation, chronic numbing of emotional experience, dysphoria and avoidance of affectively laden situations (including positive experiences), and maladaptive coping strategies (eg, substance use). These children therefore often present as emotionally labile, with extreme rapidly escalating responses to minor stressors.

The long-term effect of complex trauma on affect regulation is illustrated by the findings of twin studies, where genetic and family factors were controlled.⁹ Children who experienced sexual abuse involving penetration had

responding to social support.

ADAPTATION TO COMPLEX TRAUMA IN THE FAMILIAL CONTEXT

The response of the child's social support system, and particularly the child's mother, is perhaps the most important factor in determining the child outcomes and is more important than objective elements of the victimization itself.²⁴ Caregiver support is a critical mediating factor in determining how children adapt to victimization. Familial support and parental emotional functioning strongly mitigate the development of PTSD symptoms and enhance a child's capacity to resolve the symptoms.²⁵

There are three main elements in caregivers' responses to their children's trauma: believing and validating their child's experience, tolerating the child's affect, and managing the caregivers' own emotional response. When a caregiver denies the child's experiences, the child is forced to act as if the trauma did not occur. The child also learns he or she cannot trust the primary caregiver and does not learn to use language to deal with adversity.

Also, it is not caregiver distress per se that is necessarily detrimental to the child. Instead, when the caregiver's distress overrides or diverts attention away from the needs of the child, the child is adversely affected. Children may respond to their caregiver's distress by avoiding or suppressing their own feelings or behaviors, by avoiding the caregiver altogether, or by becoming "parentified" and attempting to reduce the distress of the parent.²⁶

In addition, victimized children often rekindle painful feelings in caretaking adults. Caregivers who have had impaired relationships with attachment figures in their own lives are especially vulnerable to problems in raising their own children. Caregivers' ability to access information about their own childhood and to tell their own story coherently may be the strongest indicators of parental capacity and effective parenting.²⁷

Caregivers with histories of childhood complex trauma may avoid experiencing their own emotions, which may make it difficult for them to respond appropriately to their child's emotional state. Parents and guardians may see a child's behavioral responses to trauma as a personal threat or provocation, rather than as a reenactment of what happened to the child or a behavioral representation of what the child cannot express verbally. The victimized child's simultaneous need for and fear of closeness (ie, disorganized attachment) also can trigger a caregiver's own memories of loss, rejection, or abuse, and diminish parenting abilities.

ETHNOCULTURAL ISSUES

Children's risk of exposure to complex trauma also can be affected by where they live and by their ethnocultural heritage and traditions (eg, war/genocide are prevalent in some parts of the world; inner cities are frequently plagued with high racial tension).²⁸ Children, parents, teachers, religious leaders, and the media from different cultural, national, linguistic, spiritual, and ethnic backgrounds define key traumarelated constructs in many different ways and with different expressions (eg, flashbacks may be "visions," hyperarousal may be "ataque de nervios," dissociation may be spirit possession).²⁹ The threshold for defining a complex trauma reaction as a problem warranting intervention differs not only across national and cultural groups, but also within sub-groups (eg, geographic regions of a country with different subcultures; different religious communities within the same geographic area).

RESILIENCE FACTORS

A victimized child may function well in certain domains (eg, academic) while exhibiting distress in others.³⁰ Areas of competence also can shift as children are faced with new stressors and developmental challenges. The factors that have been shown to be linked to children's resilience in the face of stress mirror the seven domains affected by complex trauma:³⁰

- * Positive attachment and connections to emotionally supportive and competent adults within a child's family or community (attachment).
- * Development of cognitive and self-regulation abilities (affect regulation, cognition, altered consciousness, biology).
- * Positive beliefs about oneself (selfconcept).
- * Motivation to act effectively in one's environment (behavioral control).

Additional individual factors associated with resilience include an easygoing disposition, positive temperament, and sociable demeanor; internal locus of control and external attributions for blame; effective coping strategies; degree of mastery and autonomy; special talents; and creativity and spirituality.³¹

COMPREHENSIVE ASSESSMENT OF COMPLEXTRAUMA IN CHILDREN

superior to nonspecific supportive therapies. Those programs, however, are in an early phase of development and require refinement and adaptation for culturally and geographically diverse populations. Finally, there is consensus that interventions should build strengths as well as reduce symptoms. In this way, treatment for children and adolescents also serves as a prevention program against poor outcomes in adulthood.

[Sidebar]

EDUCATIONAL OBJECTIVES

1. Describe a new theoretical framework for understanding complex trauma in children.
2. Explain how to apply new framework to assessment of traumatized children and families.
3. Discuss intervention models designed specifically for traumatized children and their families.

[Sidebar]

SIDEBAR 1.

Domains of Impairment in Children Exposed to Complex Trauma

I. Attachment

Problems with boundaries

Distrust and suspiciousness

Social isolation

Interpersonal difficulties

Difficulty attuning to other people's emotional states

Difficulty with perspective taking

II. Biology

Sensorimotor developmental problems

Analgesia

Problems with coordination, balance, body tone

Somatization

Increased medical problems across a wide span (eg, pelvic pain, asthma, skin problems, autoimmune disorders, pseudoseizures)

III. Affect regulation

Difficulty with emotional self-regulation

Difficulty labeling and expressing feelings

Problems knowing and describing internal states

Difficulty communicating wishes and needs

IV. Dissociation

Distinct alterations in states of consciousness

Amnesia

Depersonalization and derealization

Two or more distinct states of consciousness

Impaired memory for state-based events

V. Behavioral control

Poor modulation of impulses

Self-destructive behavior

Aggression toward others

Pathological self-soothing behaviors

Sleep disturbances

Eating disorders

Substance abuse

Excessive compliance

Oppositional behavior

Difficulty understanding and complying with rules

Reenactment of trauma in behavior or play (eg, sexual, aggressive)

VI. Cognition

Difficulties in attention regulation and executive functioning

Lack of sustained curiosity

Problems with processing novel information

Problems focusing on and completing tasks

Problems with object constancy

Difficulty planning and anticipating

Problems understanding responsibility

Learning difficulties

Problems with language development

Problems with orientation in time and space

VII. Self-concept

Lack of a continuous, predictable sense of self

Poor sense of separateness

10. Fergusson DM, Horwood LJ, Lynskey MT. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood: II. Psychiatric outcomes of childhood sexual abuse. *J Am Acad Child Adolesc Psychiatry*. 1996;35(10):1365-1374.
11. Putnam F. Ten-year research update review: child sexual abuse. *J Am Acad Child Adolesc Psychiatry*. 2003;42(3):269-278.
12. Zlotnick C, Ryan C, Miller I, Keitner G. (1995). Childhood abuse and recovery from depression. *Child Abuse Negl*. 1995;19(12):1513-1516.
13. Putnam FW. *Dissociation in Children and Adolescents: A Developmental Perspective*. New York, NY: The Guilford Press; 1997.
14. Stein MB, Koverola C, Hanna C, Torchia MG, McClarty B. Hippocampal volume in women victimized by childhood sexual abuse. *Psychol Med*. 1997;27(4):951-959.
15. Demitrack MA, Putnam FW, Rubinow DR, et al. Relation of dissociative phenomena to levels of cerebrospinal fluid monoamine metabolites and beta-endorphin in patients with eating disorders: a pilot study. *Psychiatry Res*. 1993;49(1):1-10.
16. Crittenden PM, DiLalla DL. Compulsive compliance: the development of an inhibitory coping strategy in infancy. *J Abnorm Child Psychol*. 1988;16(5):585-599.
17. Egeland B, Sroufe LA, Erickson M. (1983). The developmental consequence of different patterns of maltreatment. *CAiW Abuse Negl*. 1983;7(4):459-469.
18. Culp R, Watkins R, Lawrence H, et al. Maltreated children's language and speech development: abused, neglected, and abused and neglected. *First Language*. 1991;11(3 Pt 3):377-389.
19. Beers SR, De Bellis MD. Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *Am J Psychiatry*. 2002;159(3):483-486.
20. Shonk SM, Cicchetti D. Maltreatment, competency deficits, and risk for academic and behavioral maladjustment. *Dev Psychol*. 2001; 37(1):3-17.
21. Trickett P, McBride-Chang C, Putnam F. The classroom performance and behavior of sexually abused females. *Dev Psychopathol*. 1994;6:183-194.
22. Schneider-Rosen K, Cicchetti D. Early selfknowledge and emotional development: Visual self-recognition and affective reactions to mirror self-images in maltreated and nonmaltreated toddlers. *Dev Psychopathol*. 1991 ; 27:471-478.
23. Bowlby J. *A secure Base: Parent-child Attachment and Healthy Human Development*. New York, NY: Basic Books; 1988.
24. Finkelhor D, Kendall-Tackett K. A developmental perspective on the childhood impact of crime, abuse and violent victimization. In: Cicchetti D, Toth S, eds. *Rochester Symposium on Developmental Psychopathology and Developmental Perspectives on Trauma*. Rochester, NY: University of Rochester Press; 1997:1032.
25. Cohen JA, Mannarino AP, Berliner L, Deblinger E. Trauma-focused cognitive behavioral therapy for children and adolescents: an empirical update. *J Interpers Violence*. 2000;15(11):1202-1223.
26. Deblinger E, Heflin A. *Cognitive Behavioral Interventions for Treating Sexually Abused Children*. Thousand Oaks, CA: Sage Publications; 1996.
27. Main M, Goldwyn R. *Adult Attachment Rating and Classification Systems, Version 6.0*. Berkeley, CA: University of California at Berkeley; 1994.
28. Garbarino J, Kostelny K, Grady J. Children in dangerous environments: child maltreatment in the context of community violence. In: Cicchetti D, Toth S, eds. *Child Abuse, Child Development, and Social Policy*. Norwood, NJ: Ablex Publishing; 1993:167-189.
29. Loo C, Fairbank J, Scurfield R, et al. Measuring exposure to racism: development and validation of a Race-Related Stressor Scale (RRSS) for Asian American Vietnam veterans. *Psychol Assess*. 2001;13(4):503-520.
30. Luthar SS, Cicchetti D, Becker B. (2000). The construct of resilience: a critical evaluation and guidelines for future work. *Child Dev*. 200;71(3):543-562.
31. Werner AA, Smith AE. *High Risk Children from Birth to Adulthood*. Ithaca, NY: Cornell University Press; 1992.
32. Briere J, Spinazzola J. Phenomenology and psychological assessment of complex posttraumatic states. *J Trauma Stress*. In press.
33. Cloitre M, Koenen K, Cohen LR, Han H. Skills training in affective and interpersonal regulation followed by exposure: a phase-based treatment for PTSD related to childhood abuse. *J Consult din Psychol*. 2002;70(5):1067-1074.
34. DeRosa R, Pelcovitz D, Kaplan S, et al. *Group Treatment for Adolescents With Complex PTSD Manual*. North Shore University Hospital, Adolescent Trauma Treatment Development Center, National Child Traumatic Stress Network. 2003.
35. Hembree-Kigin TL, McNeil CB. *Parent-Child Interaction Therapy*. New York, NY: Kluwer Academic/Plenum Press; 1995.
36. Kagan R. *Rebuilding Attachments With Traumatized Children: Healing from Losses, Violence, Abuse, and Neglect*. Binghamton, NY: Haworth Press. In press.
37. Lanktree C. Treatment of complex trauma in children and adolescents: an integrative, empirically based model. Paper presented at: 19th Annual Meeting of the International Society of Traumatic Stress Studies; November 1,2003; Chicago, IL.
38. Lieberman AF, Van Horn P, Grandison CM, Pekarsky JH. Mental health assessment of infants, toddlers, and preschoolers in a service program and a treatment outcome research program. *Infant Ment Health J*. 1997;18(2):158-170.
39. Ford JD, Russo E, Mullen S. Integrating posttraumatic stress disorder (PTSD) and substance abuse disorder treatment. *J Couns Dev*. In press.

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